Release of Records

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706-552-1600

706-552-5370 Fax

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

_____ I authorize the physician/ facility listed below to release my records to Athens Healthcare for Women.

_____ I authorize Athens Healthcare for Women to release my records to the physician/ facility listed below.

Physician/Facility name: _____

Address: _____

Phone: _____ Fax: _____

I understand this authorization includes release of all medical records and protected health information.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____